STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is included in the cost basis used to set the Medicaid rate.

Health care practitioner services included in a per diem, ~~per monthly, or DRG~~ rate may be provided by telehealth technologies when they otherwise meet the requirements set forth in state regulations, as amended. These services are included in the appropriate cost reports or other accounting data used to calculate the rate.

Payment for Telehealth Transmission Costs: Telehealth transmission costs are allowable costs when they otherwise meet the requirements set forth in state regulations, as amended. These costs are included in the appropriate cost reports or other accounting data used to calculate the rate.

The Department covers transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Ambulatory Surgical Centers:

Payment of facility fees for services provided in an ambulatory surgical center (both free-standing and hospital-affiliated) is made at the rate established by Medicare for the appropriate group of procedures.

If one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure.

Insertion of intraocular lens prosthesis with cataract extration is considered two procedures; payment is made at 150 percent of the applicable group rate. If this procedure is performed bilaterally, payment is made at 150 percent of the group rate for the first procedure (first eye) and 100 percent for the second procedure (second eye).

The ambulatory surgical center may also provide services which are not directly related to the performance of a surgical procedure, such as durable medical equipment, medical supplies, and ambulance services. Payment for these services will be made according to the methods and standards elsewhere in the Title XIX Plan for the appropriate service.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DENTAL SERVICES

For dates of service on or after August 1, 1989, NMAP pays for dental services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PHYSICAL THERAPY

For dates of service on or after August 1, 1989, NMAP pays for physical therapy services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

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Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHOD AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PHYSICAL THERAPY

Reimbursement rates for Medicaid-covered physical therapy services provided to students through the Nebraska Public School system shall be established on the basis of actual cost to school districts in the following areas, respectively:

1. Omaha Public School District;
2. Lincoln Public School District; and
3. All other public school districts (average aggregate cost).

The basis for actual costs shall be as outlined in OMB Circular A-87. The rates shall be based on reasonable and adequate costs associated with physical therapy. These rates shall be established and updated annually based on the Department's review of the costs that are consistent with efficiency, economy, and quality of care. The State's annual review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OCCUPATIONAL THERAPY

NMAP pays for occupational therapy services provided by independent providers at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHOD AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OCCUPATIONAL THERAPY

Reimbursement rates for Medicaid-covered occupational therapy services provided to students through the Nebraska Public School system shall be established on the basis of actual cost to school districts in the following areas, respectively:

1. Omaha Public School District;
2. Lincoln Public School District; and
3. All other public school districts (average aggregate cost).

The basis for actual costs shall be as outlined in OMB Circular A-87. The rates shall be based on reasonable and adequate costs associated with occupational therapy. These rates shall be established and updated annually based on the Department's review of the costs that are consistent with efficiency, economy, and quality of care. The State's annual review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST)

For dates of service on or after August 1, 1989, NMAP pays for services for individual with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

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Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHOD AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS WITH SPEECH, HEARING, AND LANGUAGE DISORDERS (PROVIDED BY OR UNDER THE SUPERVISION OF A SPEECH PATHOLOGIST OR AUDIOLOGIST) (cont'd)

Reimbursement rates for Medicaid-covered services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist) provided to students through the Nebraska Public School system shall be established on the basis of actual cost to school districts in the following areas, respectively:

1. Omaha Public School District;
2. Lincoln Public School District; and
3. All other public school districts (average aggregate cost).

The basis for actual costs shall be as outlined in OMB Circular A-87. The rates shall be based on reasonable and adequate costs associated with the services. These rates shall be established and updated annually based on the Department's review of the costs that are consistent with efficiency, economy, and quality of care. The State's annual review and update of these rates will consider cost information related to therapists' salaries and benefits; support materials and supplies; travel; and indirect costs.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATE

PRESCRIBED DRUGS

Federal Upper Limit (FUL): Certain multiple source drug products will have an upper limit of reimbursement assigned by the Federal Government. This limit is equal to 150 percent of the product's lowest price that is published in current national compendia of drug cost information. Additionally, at least three suppliers must list the product which has been classified by the Food and Drug Administration as category A in its most recent publication of Approved Drug Products with Therapeutic Equivalence Evaluations.

All pharmacies will be notified by the Nebraska Department of Health and Human Services Finance and Support as to which products the Medicaid Division has designated as FUL products and what their respective FUL values are.

State Maximum Allowable Cost (SMAC): Certain drug products available from multiple manufacturers will have a state maximum allowable cost designated by the Medicaid Division. The SMAC value is the cost at which the drug is widely and consistently available to pharmacy providers in Nebraska. The determination of which products are designated SMAC products is the direct responsibility of the Medicaid Division in conjunction with the Nebraska Pharmacists Association Medicaid Advisory Committee. Any individual or organization may at any time request a revision in a SMAC value directly from the Nebraska Department of Health and Human Services Finance and Support.

All pharmacists will be notified by the Nebraska Department of Health and Human Services Finance and Support as to which products have been designated as SMAC products and what their respective SMAC values are.

Estimated Acquisition Cost (EAC): All drug products, including the FUL/SMAC products, will be assigned an estimated acquisition cost. The EAC of any product will be the actual cost at which most Nebraska providers may obtain the product. The Nebraska Department of Health and Human Services Finance and Support will be responsible for assigning the EAC values to all drugs. Any individual or organization may at any time request a revision in an EAC value directly from the Department.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PRESCRIBED DRUGS (Continued)

Cost Limitations: The Nebraska Medicaid Drug Program is required to reimburse product cost at the lowest of:

1. Product cost (FUL, SMAC, or EAC) plus the appropriate dispensing fee(s);
2. The pharmacy's usual and customary charge to the general public; or
3. Payment levels for all drugs will not exceed, in the aggregate, upper levels of reimbursement established by federal code or regulation.

The FUL or SMAC limitations will not apply in any case where the prescribing physician certifies that a specific brand is medically necessary. In these cases, the EAC will be the maximum allowable cost.

Dispensing Fees

Retail Pharmacies:

1. "Assigned" Dispensing Fee: A dispensing fee is assigned by the Nebraska Department of Health and Human Services Finance and Support to each individual retail pharmacy and hospital pharmacy. The fee is calculated from the information obtained through the Department's prescription survey. The Department notifies each pharmacy of its dispensing fee. If a pharmacy accepts a lesser fee from any other third party program, the Department may adjust its assigned dispensing fee to reflect this variance in total charge.
2. "Dispensing Physicians: The Department assigns a dispensing fee to a dispensing physician only when there is no pharmacy within a 25-mile radius of the physician's place of practice.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

DENTURES

For dates of service on or after August 1, 1989, NMAP pays for dentures at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

PROSTHETIC DEVICES

NMAP pays for covered durable medical equipment, medical supplies, orthotics and prosthetics, at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

EYEGLASSES

NMAP pays for covered eyeglasses at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount; or
   d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
   e. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

Revisions of the Fee Schedule: The Department may adjust the fee schedule to:

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure that was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

Transmittal # MS 00-06

Supercedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-93-15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SCREENING SERVICES

NMAP pay for covered screening services at the lower of:

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as:
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

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2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable among for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is:
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SERVICES FOR INDIVIDUALS AGE 65 OR OLDER IN INSTITUTIONS FOR MENTAL DISEASES

1. Inpatient Hospital Services

   See Attachment 4.19-A

2. Skilled Nursing Facility Services

   See Attachment 4.19-D

3. Intermediate Care Facility Services

   See Attachment 4.19-D

ATTACHMENT 4.19-B
Item 15

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INTERMEDIATE CARE FACILITY SERVICES

See Attachment 4.19-D

Transmittal # MS-00-06

Supersedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # 83-21

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

INPATIENT PSYCHIATRIC FACILITIES FOR INDIVIDUALS AGE 21 OR YOUNGER

NMAP pays for inpatient psychiatric facility services for individuals age 21 or younger provided by hospitals at the rates established under the reimbursement plan for hospital services in Attachment 4.19-A.

NMAP pays for inpatient psychiatric facility services for individuals age 21 or younger provided by residential treatment centers and treatment group homes as follows:

Payment rates for these services are established on a unit (per day) basis. Rates are set annually. Rates are set prospectively for the annual rate period and are not adjusted during the rate period. Providers are required to submit annual cost reports on a uniform cost reporting form. In determining payment rates, the Department will consider those costs that are reasonable and necessary for the active treatment of the clients being served. Those costs include costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning.

The Department cannot guarantee that all costs will be reimbursed. The submitted cost reports are used only as a guide in the rate-setting process. Payment rates do not include the costs of providing educational services.

Payment for services provided by JCAHO-accredited facilities will include payment for room and board.

Services provided by inpatient psychiatric facilities that are state-operated are reimbursed at a rate that includes all reasonable and necessary costs of operation, excluding educational services. State-operated centers will receive an interim payment rate, with an adjustment to actual costs following the cost reporting period.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Telehealth Services: Payment for telehealth services is included in the cost basis used to set the Medicaid rate.

Health care practitioner services included in a per diem rate may be provided by telehealth technologies when they otherwise meet the requirements set forth in state regulations, as amended. These services are included in the appropriate cost reports or other accounting data used to calculate the rate.

Payment for Telehealth Transmission Costs: Telehealth transmission costs are allowable costs when they otherwise meet the requirements set forth in state regulations, as amended. These costs are included in the appropriate cost reports or other accounting data used to calculate the rate.

The Department covers transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

NURSE MIDWIFE SERVICES

Payment for nurse-midwife services is made to the nurse-midwife or the physician with whom the nurse-midwife has a practice agreement; the physician is then responsible for payment to the nurse-midwife. Payment for nurse-midwife services is made at the lower of:

1. The provider's submitted charge; or
2. A percentage, determined by the Department, of the amount allowable under Item 5 of Attachment 4.19-B for the physician with whom the nurse-midwife has a practice agreement.

NMAP covers pre-natal care, delivery, and postpartum care as a "package" service. Auxiliary services, such as pre-natal classes and home visits, are not paid as separate line items.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two way interactive audiovisual transmission as set forth in state regulations, as amended.
